eHealth Financing Workgroup Charter Activities and Recommendations

Responsibilities:
Develop options for funding electronic health records in all size health care settings and for the operation of a statewide public-private health information infrastructure.

Assumptions and premises underlying draft recommendations:
- Financing is needed for three levels of infrastructure: 1) appropriate HIT adoption and use by providers, 2) HIE through RHIOs or other exchange mechanisms at the regional level, and 3) statewide HIE.
- The RHIO concept does not capture a standard set of information exchange activities or functions, and thus the acronym does not describe any specific model. Rather, the ehealth Finance Work Group will focus on recommendations for financing designated individual functions and step-wise, phased-in modular adoption of functions.
- The definition of the scope and functions of a state-level RHIO effort will determine the strategies for obtaining long-terms sustainable financing.
- The plan will require phase in over time, but HIE promotion should not crowd out resources for bring all providers are at a baseline level of capability for internal clinical and patient safety systems and the internal capture and aggregation of data.
- Marginal costs must correspond with marginal benefits. This will vary by type of provider/constituent, but each stakeholder needs to realize a proportional ROI.
- The system requires re-engineering processes and workflow, and adoption phase-in will incur productivity costs.
- The system requires consistency of platforms and standards for inter-operability.
- Approach must be statewide, politically feasible, consistent with federal initiatives.
- Must accommodate existing efforts and incorporate legacy systems. Avoid creating multiple login environments where HIT exists but interface capability is currently lacking.
- Low volume - particularly low volume unaffiliated – organizations may need help implementing EHR systems.
- Costs of participation in HIE need to be scaled for smaller rural communities, with consideration of the relative benefits in various markets.
- HIE will allow for flexible flow of clinical data across systems and referral centers, rather than limiting access within existing referral relationships and proprietary networks.
- The Wisconsin eHealth Action Plan will provide overall cost estimates and strategies: The actual RHIOs will develop business plans and a clear value model for each HIE function they pursue.
- HIE functions most commonly pursued in the first two years are as follows: clinical messaging, medication reconciliation, PH outbreak surveillance, electronic referrals and authorizations, electronic signature, e-prescribing, P4P/quality data reporting, electronic billing support. (eHealth Initative ToolKit)

Assignments:	Draft Findings & Recommendations
1) Articulate the value on investment and the business case for investment in health information exchange.	- The business case and ROI for electronic health records, HIT and HIE has not been well established in practice, but only in theory through modeling and projections in the literature. - The literature reports a wide range of costs associated with HIT; Fiscal estimates of implementation will reflect that range. - A RAND analysis estimated that national adoption of the EHR could lead to "more than $81 billion" in annual savings. - But Goodman and colleagues, also writing in Health Affairs: "It is unrealistic to hold out widespread adoption of HIT as a net cost saver." "Do It for the Quality." - HIE: Walker and colleagues, writing in Health Affairs, estimated that information exchange across providers, hospitals, public health, and payers, could save $77.8 billion annually. <u>**HIT: Business Case**</u> <u>Estimated Start-Up and Maintenance Expanses</u> - Solo and small group practices: $44K start-up, $8.5K/year maintenance (Miller, 2005) - MGMA average: $33K start-up, $1.5K/year maintenance <u>ROI gains by category (Miller 2005)</u> - The average practice paid for its EHR in 2.5 years and gained more than $23K in net benefits per FTE providers. Gross financial benefits $33K/FTE/year (range $1K-$42K): - Increased coding levels – 52% of benefits - $17K average - Efficiency related - 48% of benefits- average $15K per FTE provider. (40% from decreased personnel costs and 8% from increased patient visits.) <u>Productivity gains:</u> - Lowering personnel costs: EHR can enable clerical staff reductions amounting to $13K per physician per year. (Miller, 2005) - But one analysis shows EHR increased documentation time among physicians by about 17%, while CPOE increased it by 98%. (Poissant 2005) - Kaiser Permanent EHR resulted in 5-9% decrease in office visits replaced by telephone contacts. (Garrido, 2005) <u>Billing Optimization:</u> - EHR can "auto-populate or scour the medical record to justify a greater intensity of services. "Increased coding levels," better "capture of charges" and fewer "billing errors" can produce ROI. (Miller 2005, Wang 2003) - Arguably, as physicians are prone to under-documentation, EHRs can increase health care costs by billing more for the same services without any corresponding increase in quality (Sidorov 2006)

Assignments:	Draft Findings & Recommendations
	Quality and Safety: • Evidence is mixed. Physicians might resent the loss of professional autonomy or have limited tolerance for on-screen prompts. • "The EHR has yet to be quantified or consistently used to reduce malpractice premiums or health care costs." (Sidorov 2006) • "The EHRs greatest promise arguably lies in the support of [patient centeredness, shared decision making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management], versus the prospect of less efficiency, greater costs, inconsistent quality, and unchanged malpractice burdens resulting from a simple engraftment into the current health care system." (Sidorov 2006) **HIE Business Case:** Santa Barbara County financial analysis • found "positive returns to HIE in all except small communities (e.g., one hospital and less than 100 physicians), even they ignoring improvements in clinical efficiency. In one-hospital markets, there is little difference between enterprise-data access and regional data sharing, so...these markets do not have a business case for sharing data beyond the enterprise." • At face value, HIE provides moderate ROI. Overall magnitude of returns is relatively low. • But peer-to-peer technology can scale the benefit to the cost of operation and carries little overhead. Can be self-funded. • Key variable is physician adoption and use: ROI is complete related to lowering the volume of manual data handling. • NIHIT Briefing (2005): "hospitals and providers foot 97% of the ongoing costs (of information exchange), yet receive just 56% of the potential benefits. The remaining benefits are dispersed among payers and other stakeholders." ROI by constituent in Medium and Large Regions • Each constituent benefits from providing data to any set of physicians on an enterprise level (stand-alone web-enablement or one-to-one interaction), without "regionalization." • Organization gains benefits from participation in the regional network, arising from having a single place for physicians to get all relevant data for their patients (i.e. many-to-many interaction). • Physician offices get a very high rate of return in the form of office efficiencies. • Imaging center have a slightly negative return from regional component, but is balanced by positive return from stand-alone web-enablement. • Every organization has positive overall returns from regional data sharing.

Assignments:	Draft Findings & Recommendations

	Low Hanging Fruit for Early Wins
	    ▪ ePrescribing, Medication mgmt, ePharmacy, CPOE
	    ▪ eLaboratory
	    ▪ On-line tools for chronic disease management
	    ▪ Emergency room data transfer (?)
	
	Potential Phase-In (North Carolina)
	Phase I: point of care medcialtion management, automated refill, formulary and benefits information, and eRx
	Phase II: elab and radiology results ordering and results at point of care.
	Phase III: EHR

2) Identify existing and potential funding sources to support development of the ehealth infrastructure.	Contributed income:
	Federal grants (AHRQ, NHIN)
	DHFS
	WI Telecommuncations Fund
	BC/BS Partnership Fund
	Other Foundation
	
	Tax Credits
	
	Potential lenders: bond issue, WHEFA
	
	Potential earned income:
	Stakeholder contributions
	Membership fees – based on size and/or usage
	Subscription/use/transaction fee – based on benefit to participants
	        ▪ $ per clinical result delivered
	        ▪ $ per covered life per month
	        ▪ $ per hour for technical assistance
	        ▪ $ per month for a license to use a particular software package over the web.
	Programs or Service fee: for example, for participation in group purchasing arrangements, educational services.

3) Examine approaches and successful examples of financial strategies to increase adoption of health information	More than 70% of RHIO income, on average, from grants and other forms of contributed income. (Healthcare IT Transition Group, 2006).
	    ▪ Expect as much as 1/3 of total RHIO revenues from government granst and philanthropy
	    ▪ While does not resemble a commercial enterprise or fee-based nonprofit healthcare provider, this business model is consistent with other non-profit organizations and appropriately reflect RHIOs' role as a public good.

Assignments:	Draft Findings & Recommendations
technology and ehealth data exchange from within the state and from other regions.	Grants may supplement, but are unlikely to be a viable source for ongoing funding. (AHIMA 2006) EHR group purchasing strategies successful, with contributions from payers that are potential beneficiareis of phsyicains' use of HIT. (Rhode Island) Utah HIN only provides services that have business value to its members and for which members will pay. Includes membership fees, and per claim transaction fees.
4) Propose financing strategies for funding health information technology and ehealth for both start-up and long term including the appropriate roles of the public and private sectors.	▪ State government programs, including Medicaid, ETF, biosurveillance, and public health services, should tie in with the state-level RHIO architecture and design payment incentives for providers statewide to adoption and participate in the system. ▪ Resources should be directed to those stakeholders who must be engaged but who may lack the resources to contribute financially (safety net providers, FQHCs, RHCs, CAHs, local health departments). ▪ Many rural hospitals, in particular lack interface engines and interface expertise, and often have limited IT resources in house. They will need interfacing hardware, software, and expertsie resources to participate in HIE. ▪ Pay-for-performance incentives ▪

5) Identify specific financial actions required to support the first key product types (as identified by the Patient Care work group and approved by the Board), provide an estimate for the total cost of implementation of the first key product types and for total cost of implementation of the Wisconsin Action Plan.	Results and Document delivery
	     ▪ eLab and Decision Support
	Registration and claims record repository
	     ▪ Registration module
	     ▪ Medication-allergy-immunization record
	     ▪ Discharge summaries and progress notes
	
	HIT Adoption:
	100% HIT adoption by WI Physicians:
	     ▪ Start-up $84-$262 million
	     ▪ Maintenance: $11.9-17.9 million/year
	
	Subscription intermediate HIE model:
	     ▪ Assume $500/physician/year
	     ▪ Lab, rad, ePharmacy
	     ▪ $6 million/year for Wisconsin's 14,000 physicians
	
	EHealth Initiative HIE Cost Model:

Assignments:	Draft Findings & Recommendations
	- WI requires $563 million over two years to implement system - One-time hardware costs for Systems and Functions: $113 million - Annual software costs for processes and interfaces - up to $6.5 million for complete system - Functions: clinical messaging, medication reconciliation, PH Outbreak surveillance, electronic referrals and authorizations, electronic signature, E-prescribing, P4P/quality data reporting, electronic billing support
6) Coordinate with and give input to other groups.	In progress.
7) Present findings, analysis, and recommendations to the Board at the August 3, 2006 meeting.	

Issues for discussion:

- Will the state-level RHIO be conducting technology operations (e.g., actually hosting and sharing health care data)
- Focus of the Governor's eHealth Action Plan:
    - Will include fiscal estimates for broad/universal adoption of EHR/HIT and recommendations about how to leverage and provide incentives for such adoption.
    - Will include potential strategies and funding sources for RHIOs and other HIE initaitives.
    - Should the eHealth Action Plan includes a more detailed, comprehensive business plan for the state-level RHIO, which includes defining capital and operating expenses of the project and the sources of revenue for the project.
- Should initial funding be used for actually building out some of the technology architecture?
- What is the role for state incentives for adoption? How to assure equity for early adopters/investors/pioneers while promoting broader diffusion if technology.